

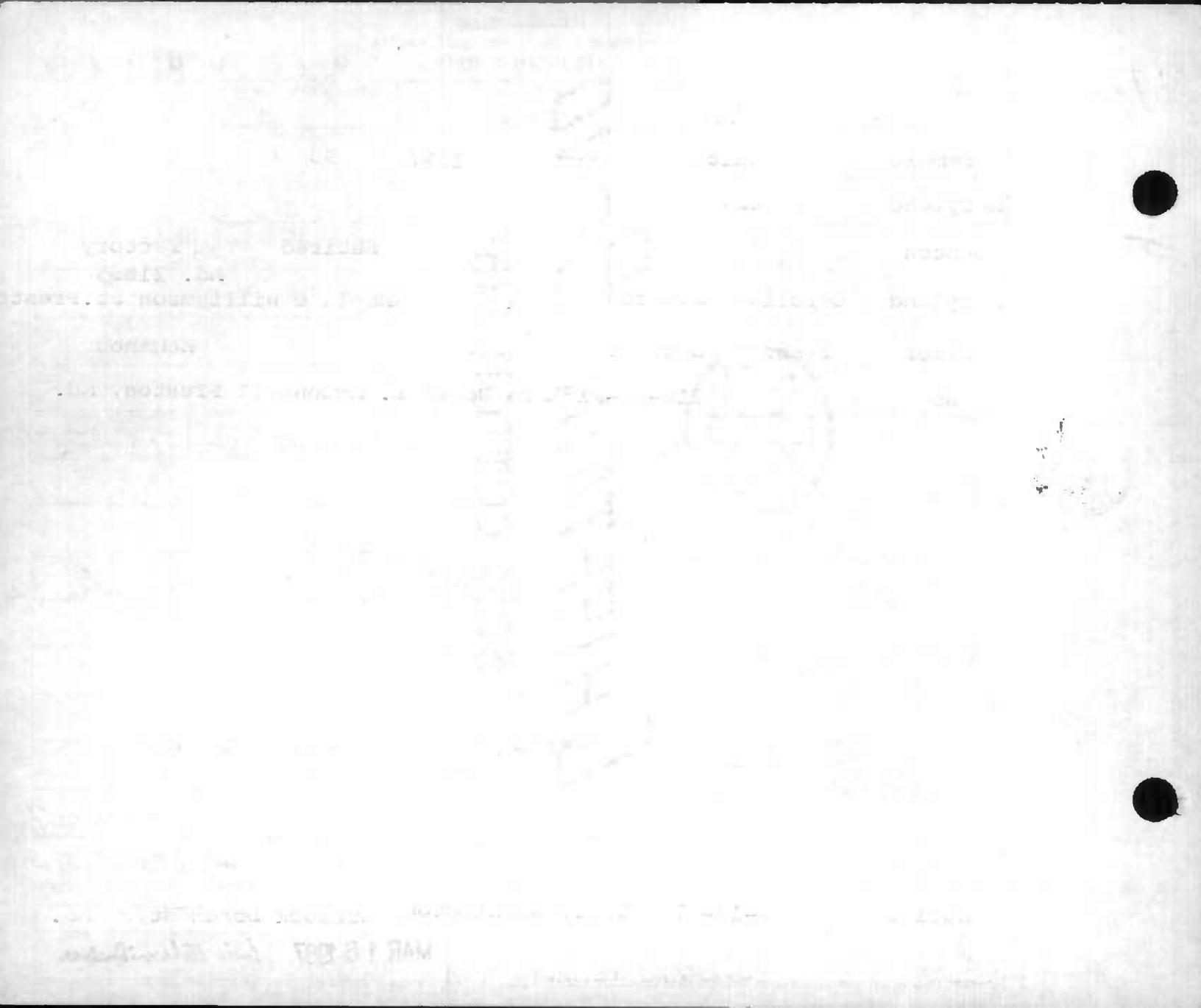
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please send the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked as having occurred, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8708075			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Hattie W. Anderson						3 10 87			34 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Female		White		2 9 1897			90						
8. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA					Caroline		Caroline				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (IF NOT IN BOX FOR PART OF WORKING LIFE)			
Denton		Caroline Nursing Home								Retired			
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Preston			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Maple & Williamson St. Preston				
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
Elmer		Franz		Lura					216-03-2153		Mrs Norma L. McConnell Preston, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. ADDRESS						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No										Pneumonia / Congestive Heart Failure		15 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost		(b)											
		DUE TO, OR AS A CONSEQUENCE OF											
		(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from <u>MARCH 15, 1983</u> to <u>MARCH 10, 1987</u> , that (II) we last saw the deceased alive on <u>MARCH 10, 1987</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) we did <input type="checkbox"/> did not view the body after death.													
22b. SIGNATURE Mary F. Campagnolo		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED 3-10-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY F. CAMPAGNOL													
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3-13-87		23c. NAME OF CEMETERY OR CREMATORIAL Unity Washington		23d. LOCATION CITY OR TOWN Hurlock		COUNTY Dorchester		STATE Md.			
24. FUNERAL DIRECTOR FEDERAL BURIAL, M.D.						25. REC'D. BY REGISTRAR MAR 16 1987		25b. REGISTRAR'S SIGNATURE Julia Jordan Justice					
BP													



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8708076 REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR	
SALLY Sallie			ANDREW			3/29/87			3/29/87			6:25 PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			9/19/ 1897			89 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD	
Delaware			U.S.A.			Caroline							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Denton			Wesleyan Nursing Home			Nurse			Nursing			21632	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland			Caroline			Federalsburg			Rt. 2, Box 375			21632	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
William Henry Dean			Annie F. Cheezman										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			213-22-6152			Hazel Hubble, Rt. 2, Box 375						2 DAYS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a PNEUMONIA													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE Bruce M. Grund												DEGREE MD	
22c. PHYSICIAN'S NAME (THE DECEASED) Bruce M. Grund												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. ADDRESS Box 122, Goldsboro, MD 21636												DATE SIGNED 3/29/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/1/87			23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest			23d. LOCATION CITY OR TOWN Federalsburg, Caroline, MD				
24. FUNERAL DIRECTOR NAME Frances - Andrew 21671, Main St. Federalsburg, MD 21632			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 06 1987			25b. REGISTRAR'S SIGNATURE Julia Sonder-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial form panel. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene provided for burial, cremation, or removal.

IMPORTANT: If Item 21 is modified or deleted, Item 18 should be struck out entirely, as either traumatic event, the medical examiner

4/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic

BP _____
DHMH - 16 50M 4/83
(VRA 15-4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

NE 87080111

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
ELLA CAROLINE CLARK						03	09	87		10 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female		White		MONTH	DAY	YEAR	100	IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTH			
Nebraska		U.S.A.					Caroline County			DAYS			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Denton		Wilhelm Rd. P.O. Box 338		Denton, Md.			Homemaker						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Denton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Wilhelm Rd./P.O. Box 338 Denton, Md 21629			
14. FATHER'S NAME FIRST MIDDLE LAST		Charles Boehl		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			Minnie Hann						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. _____		17. INFORMANT			ADDRESS						
		220/48/4319		Wayne Clark (same as 13e.)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ATRIAL FIBRILLATION</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7/31</u> , 19 <u>86</u> , to <u>3/9</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10/21</u> , 19 <u>86</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <u>J. Corwin M.D.</u>		DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>3/9/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Corwin M.D.</u>		22e. ADDRESS <u>P.O. Box 660, DENTON, MD 21629</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/10/1987		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crematory			23d. LOCATION CITY OR TOWN Baltimore, Maryland 21202			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc. Balto., Md. 21222		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 10 1987			25b. REGISTRAR'S SIGNATURE						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove certificate from this form and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic, external medical examiner must be notified at once.

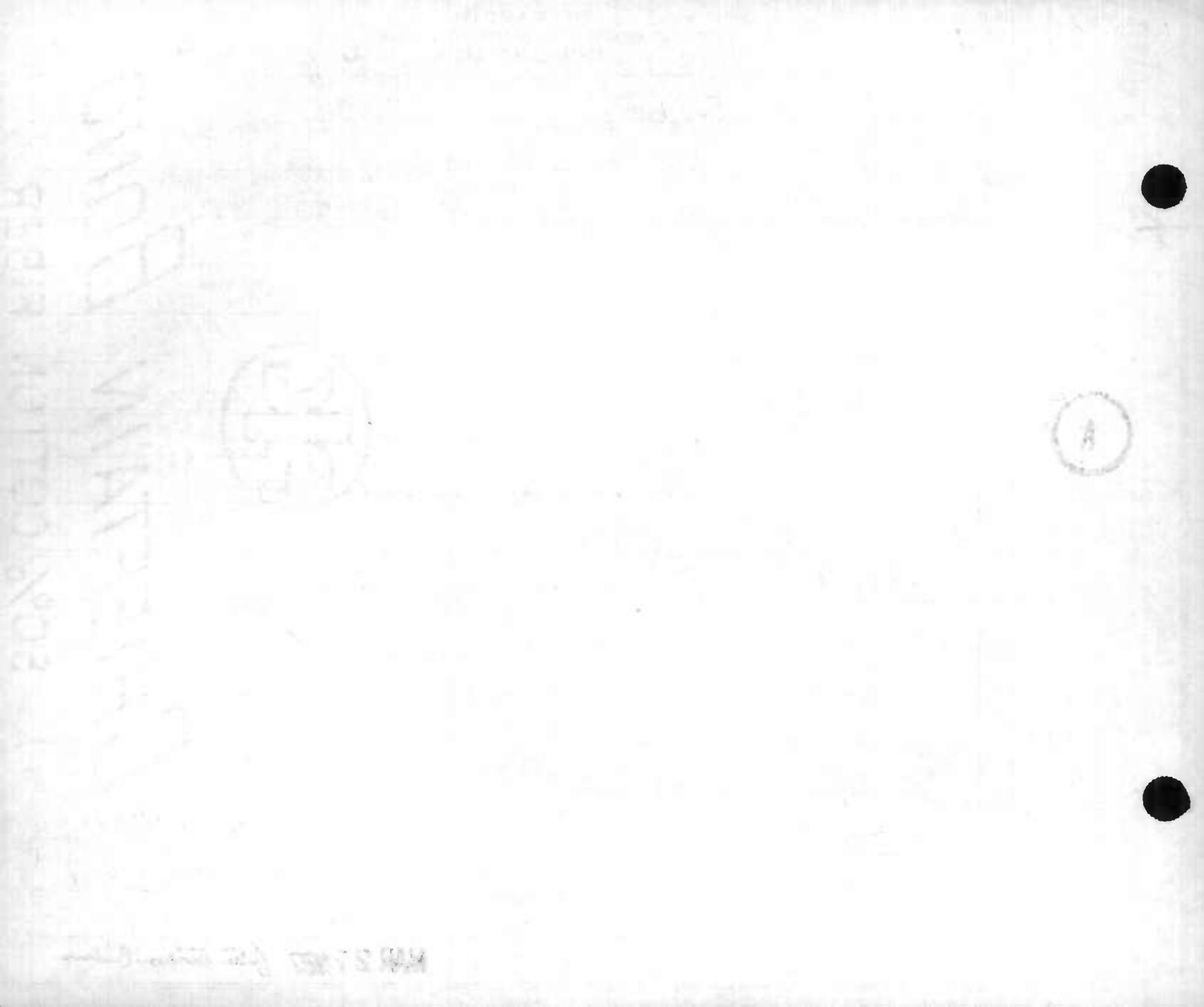
MEDICAL CERTIFICATION

2 FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8708018
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Florence Seeders Love						3 24 87				4 19 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
Female		Caucasian		Feb. 27, 1901			86 YRS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U. S. A.					Caroline					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Denton		Caroline Nursing Home								Housewife		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Caroline		Denton						Statum Road 21629		
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST					
Benaiah		Seeders		Georgianna						Spence		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		213184815		Edwin Love, Denton, Maryland 21629								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>cardio respiratory failure</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>cerebrovascular accident</i>												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>hypertension, congestive heart failure</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>J. Corwin</i>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 3/24/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Corwin</i>		22e. ADDRESS P.O. Box 666 DENTON MD 21629										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/26/87		23c. NAME OF CEMETERY OR CREMATORIAL Concord Cemetery			23d. LOCATION CITY OR TOWN Denton		COUNTY Caroline	STATE MD		
24. FUNERAL DIRECTOR NAME <i>Moore Funeral Home</i>		ADDRESS Denton, MD			25a. DATE REC'D. BY REGISTRAR MAR 27 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Lenderd Lenderd</i>				



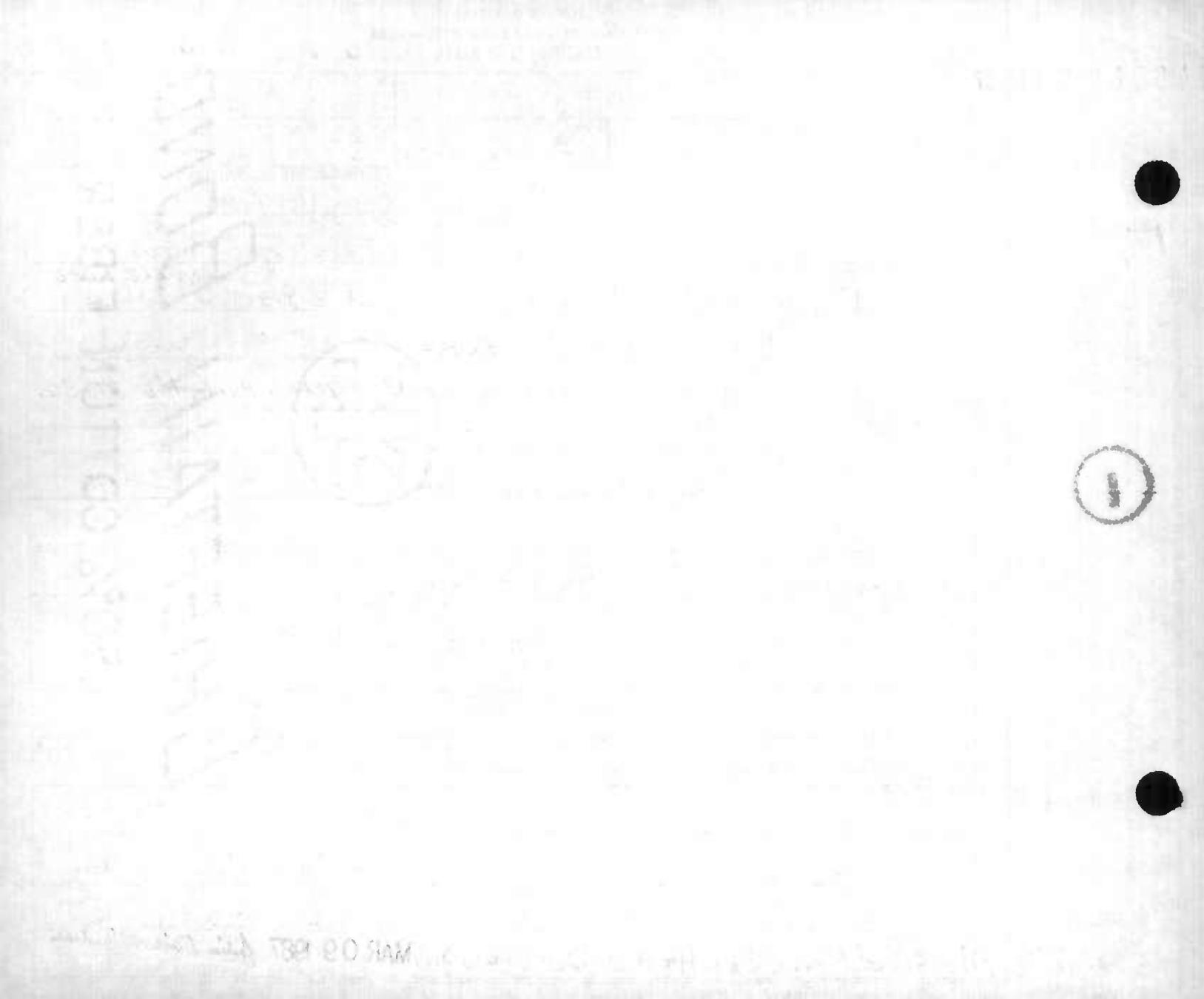
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be witnessed within 24 hours of death. It may be

signed by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return the completed pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner should be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
8708079 REG. NO.													
1- FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				
PHILIP Martin			Noble						03-02-87				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR			
Male		White		5 12 1899			87			6:50 P.M.			
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		USA						Caroline County					
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Denton		Caroline Nursing Home			Farmer			NOBLE Road					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		12c. ADDRESS			
Maryland		Caroline		Federalsburg		YES <input type="checkbox"/>		14 2 Box 166 21632		NOBLE Road 14 2 Box 166 21632			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17. INFORMANT			
Phillip		Arthur		Rosa			NO			ISABEL NOBLE, FEDERALSBURG, MD 21632			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Respiratory Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Pneumonia										3 days	
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Parkinsonism, Congestive Heart Failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) this hospital attended the deceased from 2/27, 1987, to present 3/2/87, that (1) (we) last saw the deceased alive on 2/28, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robinson Lappin		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 3/2/87					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robinson Lappin		22f. ADDRESS PO Box 122 Goldsboro Md. 21636											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3/5/87		23c. NAME OF CEMETERY OR CREMATORIAL Denton Cemetery			23d. LOCATION CITY OR TOWN Denton COUNTY Caroline STATE MD						
24. FUNERAL DIRECTOR MORRIS FUNERAL HOME DENTON		25a. DATE REC'D. BY REGISTRAR MAR 09 1987			25b. REGISTRAR'S SIGNATURE Julia D. St. John								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 4 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

048986 APR 08080

FOR
1- STATE
REGISTRAR
2- CITY
3- DECEASED NAME
(TYPE OR PRINT)
4- SEX
5- RACE
6- DATE OF BIRTH
MONTH DAY YEAR
7- BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
8- CITIZEN OF WHAT COUNTRY?
9- BALTIMORE CITY OR COUNTY OF DEATH
10- CITY OR TOWN OF DEATH
11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a- STATE
13b- COUNTY
13c- CITY OR TOWN
14- FATHER'S NAME
FIRST MIDDLE LAST
15- MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
16a- WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
16b- SOCIAL SECURITY NO.
17- INFORMANT
ADDRESS
18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **MYOCARDIAL INFARCTION**
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b) **HYPERTENSIVE CARDIOVASCULAR Disease**
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
ANGINA & CARDIAC ischemia
19a- DATE OF OPERATION
19b- CONDITION FOR WHICH OPERATION WAS PERFORMED
20- AUTOPSY?
YES NO
19c- EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH
21b- TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19
21d- INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK
21e- PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
21f- LOCATION
STREET CITY OR TOWN COUNTY STATE
22a- I certify that I took charge of the remains described above, held on
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner
22b- ACTUAL SIGNATURE *Christian Jensen*
EXAMINER'S NAME
(TYPE OR PRINT) **Christian Jensen, M.D.** ADDRESS
23a- BURIAL, CREMATION, REMOVAL
(SPECIFY)
23b- DATE
23c- NAME OF CEMETERY OR CREMATORIUM
23d- LOCATION
CITY OR TOWN
24- FUNERAL DIRECTOR
NAME
ADDRESS
Frampton-Hawkins Funeral Home, 216 N. Main
25a- DATE REC'D. BY REGISTRAR
25b- REGISTRAR'S SIGNATURE
Julie Darden-Randall

